FIRST CAVALRY DIVISION MENTAL HEALTH CLINIC MENTAL HEALTH ASSESSMENT

(Patient: Please provide the following information to assist your provider in making a complete evaluation.)

PART 1 - IDENTIFICATION DATA

Section 1A - Patient Data

Name: *(Last, First, MI)*	Home phone: *(Including Area Code)*	Today's date:

Street address:	City:	State:	Zip Code:

Unit:	Work phone: *(Including Area Code)*

Age:	Date of birth: *(DDMMYY)*	Gender: ☐ Male ☐ Female	Race: ☐ Black ☐ Caucasian ☐ Hispanic [ ] Asian ☐ Am. Indian ☐Other:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)

Section 1B - Spouse Data (in case we need to contact them)

Name: *(Last, First, MI)*	Social Security Number:	Age:	Date of birth: *(DDMMYY)*	Race: ☐ Blk ☐ Wht ☐ Hisp [ ] Asian ☐ Am Ind ☐ Other:

Unit or employer and address:	Work phone: *(Including Area Code)*

Section 1C - Sponsor Data

Name: *(Last, First, MI)*	Grade:	Branch of service: ☐ Army ☐ Navy ☐ Air Force ☐ Marine Corps ☐ Coast Guard ☐ Other:	Social Security Number:

Duty status: ☐ Active duty ☐ Retired ☐ Reserve ☐ Family member ☐ DOD	Security Clearance: ☐ Top Secret ☐ Other ☐ SCI ☐ Secret ☐ Confidential ☐ None	Personnel Reliability Program:	Military Occupational Spec:

Job title:	ETS: *(DDMMYY)*	Time in service:	Time in current unit:

Commander's Name: *(Last, First, MI)*	Grade:	Work phone	Referred by: ☐ Self ☐ Command ☐ Medical ☐ Other:

Part 2 - PRESENTING PROBLEM

a. What is (are) your reason(s) for coming in today?

b. Did anything happen within the last 24-72 hours which caused you to come in today? ☐ Yes ☐ No *(If "Yes," please explain.)*

c. How long have you been experiencing this (these) problem(s)?

d. Have you had difficulties or troubles like this before? ☐ Yes ☐ No *(If "Yes," please explain.)*

e. Please check all areas listed below which are current sources of increased stress for you.

☐ Marital ☐ Family ☐ Divorce ☐ Social ☐ Death ☐ Loss ☐ Medical ☐ Job ☐ Military ☐ Peers ☐ Legal ☐ Finances ☐ Trauma/Abuse

☐ Alcohol problems ☐ Drug problems ☐ Alcohol or drug problems with someone other than yourself ☐ Relationships ☐ School

PART 3 - PHYSICAL ASSESSMENT

Date of last physical exam:	Name of primary care doctor / Clinic Assigned	Office phone: *(Including Area Code)*

a. Have you recently experienced, or do you presently have, any of the following symptoms? ☐ Dizziness ☐ Headaches ☐ Loss of appetite ☐ Weight gain ☐ Weight Loss ☐ High blood pressure ☐ Back pain ☐ Injury ☐ Sexual problems ☐ Nicotine craving ☐ Major Illness ☐ Chest pain ☐ Pregnancy ☐ Abnormal menstrual cycle ☐ Sore throat ☐ Stomach trouble ☐ Hearing problems ☐ Bloody stool or urine ☐ Fatigue ☐ High energy ☐ Rapid pulse or breathing ☐ Slurred speech ☐ Numbness ☐ Eating problems ☐ Sleeping problems ☐ Loss of Consciousness ☐ Head Injury

☐ Other: _____

b. Are you undergoing treatment for any of the above? ☐ No ☐ Yes *(If "Yes," please explain.)*

c. List all allergies and reactions to medications:

d. List all past psychiatric medications and any current medications including over the counter medications, herbals and supplements: *(This information will help us to accurately assess your overall health condition.)*

Name of drug	Amount Taken (Dose)	Date Started	Date Stopped	Effectiveness

e. List all current and past medical or physical problems, including hospitalizations and traumas:

PART 4 - PSYCHOLOGICAL ASSESSMENT

f. Have you recently experienced, or do you presently have any of the following? ☐ Stress ☐ Loss of interest in pleasurable activities ☐ Difficulty concentrating ☐ Guilt ☐ Rage ☐ Mood swings ☐ Irritability ☐ Memory problems ☐ Loss of energy ☐ Panic/anxiety ☐ Depression ☐ Racing thoughts ☐ Flashbacks ☐ Seeing visions ☐ Hearing voices ☐ Paranoia ☐ Nightmares ☐ Poor impulse control ☐ Feeling helpless/hopeless ☐ Thoughts of hurting self ☐ Thoughts of hurting others

List any psychiatric or substance abuse evaluations, counselings and hospitalizations:

Reason	Location	Date Treatment Started	Date Treatment Ended	Diagnosis *(If known)*

g. List any biological family members who have been diagnosed or treated for any of the following problems: ☐ Depression ☐ Anxiety ☐ Hyperactivity ☐ Paranoia ☐ Manic episode(s) ☐ Bipolar disorder ☐ Schizophrenia ☐ Alcohol abuse ☐ Drug Abuse ☐ Family violence ☐ Suicide (or attempted suicide) ☐ Sexual abuse

Relationship	Problem/diagnosis	Hospitalized?	Medication prescribed *(if known)*
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

h. Have there been any deaths in your family related to the problems listed above? ☐ Yes ☐ No *(If "Yes," please explain.)*

PART 5 - SUBSTANCE USE ASSESSMENT

a. Are you experiencing any problems with alcohol or drugs at this time? ☐ No ☐ Yes *(If "Yes," please explain.)*

b. Did you ever find that you needed to drink a lot more or use more drugs in order to get an effect, or that you could no longer get high on the amount that you were using? ☐ Not applicable ☐ No ☐ Yes *(If "Yes," please explain.)*

c. Did you ever get into arguments or fights while drinking or using drugs? ☐ Not applicable ☐ No ☐ Yes *(If "Yes," please explain.)*

d. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or make yourself feel better? ☐ No ☐ Yes *(If "Yes," please explain.)*

e. Have you ever had times when you drank or used drugs to the point that you couldn't remember what you said or did the next day (i.e., blackouts)?
☐ Not applicable ☐ No ☐ Yes -- How many times? _____ *(If "Yes," please explain.)*

f. Do you smoke or use tobacco products? ☐ No ☐ Yes If "Yes," --

(1) What do you smoke or use? _____ (2) How long have you been smoking or using tobacco products? _____

(3) How much do you use in a day? _____ (4) Have you attempted to quit? ☐ No ☐ Yes *(If "Yes," how long did you quit?)* _____

(5) Are you interested in quitting? ☐ No ☐ Yes

PART 6 - EARLY FAMILY RELATIONSHIP ASSESSMENT

a. Where were you born?	b. Who raised you?	c. Parents still married? ☐ Yes ☐ No
d. At what age did they divorce?	e. How many bio. brothers do you have?	f. How many stepbrothers do you have?
g. How many bio. sister s do you have?	h. How many stepsisters do you have?	i. What number child were you?

j. What was it like in your childhood home? ☐ Loving ☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive ☐ Other:

c. Were you adopted? [ ] Yes [ ] No At what age?	l. Did your parents physically fight? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often
m. How close were to to your father?	n. How close were you to your mother?

o. What kind of discipline was used in your home?

p. Have you ever been physically abused? ☐ Yes ☐ No *(If "Yes," please explain.)*

q. Was your family ☐ Poor ☐ Middle class ☐ Wealthy ?

PART 7 - CURRENT FAMILY RELATIONSHIP ASSESSMENT

a. Are you presently married? ☐ Yes ☐ No *(If "No," skip questions b through h)*	b. How long have you been married?
c. Are you the spouse of a military member? ☐ Yes ☐ No	d. Are you and your spouse both active duty military? ☐ Yes ☐ No
e. How long did you date your spouse before getting married?	f. Are you currently living with your spouse? ☐ Yes ☐ No

g. On a scale of 1 to 10, where 1 equals "poor" and 10 equals "perfect," please rate your satisfaction with your marriage: 1 2 3 4 5 6 7 8 9 10

h. Are you having any current problems in your marriage? ☐ Yes ☐ No *(If "Yes," please explain)*

i. How many times have you been married? _____

Date of marriage	Date of divorce or death of spouse	Reason the relationship ended

j. If you still have a relationship with a former spouse, please explain:

k. Have you and/or any of your spouses ever been to counseling or any agency such as Child Protective Services or Family Advocacy because of physical, sexual, or emotional abuse? ☐ Yes ☐ No *(If "Yes," who participated in the counseling; please explain.)*

l. Please list all your children:

Child's name	Child's age	Child's sex	Is this a biological child or stepchild?	Does this child currently reside with you?

m. Does anyone else reside in your household? ☐ Yes ☐ No *(If yes, please list names, ages, and relationships.)*

PART 7 - CURRENT FAMILY RELATIONSHIP ASSESSMENT *(Continued)*

n. Do you have weapons in your home? ☐ Yes ☐ No *(If "Yes," please check all that apply.)*

☐ Handgun(s) ☐ Rifle(s) ☐ Hunting or combat knife/knives ☐ Other:

o. Are you having any problems with your children? ☐ Yes ☐ No *(If "Yes," please explain.)*

p. How do you discipline your children?

o. Are you presently having any problems with your in-laws or parents? ☐ Yes ☐ No *(If "Yes," please explain.)*

PART 8 - SOCIAL SUPPORT ASSESSMENT

a. Do you have someone you can talk to when you have a problem? ☐ Yes ☐ No

b. How many close friends do you have? _____

c. Is there someone you would ask for help if you needed it? ☐ Yes ☐ No

d. Who would you say really cares about you? _____

e. Are you geographically isolated from your family and friends? ☐ Yes ☐ No

f. Are you having trouble in your relationships with family or friends? ☐ Yes ☐ No

g. Have you recently withdrawn from friends or family? ☐ Yes ☐ No

h. Do you belong to any groups or organizations that are supportive and helpful to you? ☐ Yes ☐ No *(If yes, please explain.)*

PART 9 - PERCEPTION OF OWN STRENGTHS AND WEAKNESSES

a. What do you like about yourself:

b. What do you dislike about yourself:

c. What special skills, talents or aptitudes do you have?

d. Are there any of the following areas you would like to change? ☐ Too easily influenced by others ☐ Too impulsize ☐ Uncertain of what I want
☐ Have difficulty making decisions ☐ Don't express thoughts/feelings well ☐ Too easily angered ☐ Have trouble getting along with people

Please list anything else you are concerned about:

PART 10 - SPIRITUAL/CULTURAL ASSESSMENT

a. What is your religious/spiritual affiliation?

b. Select all of the following that currently apply to you: ☐ Losing my earlier faith/religion ☐ Not going to church often enough ☐ Not getting satisfactory answers from my faith/religion ☐ Needing to talk with chaplain/pastor ☐ Nonecurrently apply to me

c. How much is your religion/spirituality a source of strength and comfort to you? ☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

d. How important a part of your daily life is your religion/spirituality? ☐ None ☐ Not much ☐ Some ☐ Quite a bit ☐ A great deal

e. Has your present problem/illness affected your religious/spiritual life? ☐ Yes ☐ No *(If "Yes," how?)*

f. Do you belong to any special groups that relate to your ethnic background/nationality or political/spiritual beliefs? ☐ Yes ☐ No *(If "Yes," please explain.)*

g. Do you have an religious/spiritual practices that the provider needs to be aware of during treatment? ☐ Yes ☐ No *(If "Yes," please explain.)*

PART 11 - EDUCATIONAL ASSESSMENT

a. Highest level of education completed: ☐ Elementary school ☐ Junior high school ☐ High school ☐ Technical school ☐ Some college ☐ 2-Yr college degree ☐ 4-Yr college degree ☐ Graduate school ☐ Other:

b. Are you currently in school? ☐ Yes ☐ No *(If "Yes," how has your problem impacted your performance?)*

c. Did you repeat any grades? ☐ Yes ☐ No *(If "Yes," please explain.)*

d. Did you skip any grades? ☐ Yes ☐ No *(If "Yes," please explain.)*

e. Did you ever have problems reading? ☐ Yes ☐ No *(Comprehension, retention or speed if "Yes," please explain.)*

f. Were you ever in any special education/gifted classes? ☐ Yes ☐ No *(If "Yes," please explain.)*

g. Did you ever have any disciplinary problem in school? ☐ Yes ☐ No If yes, were you ever suspended or expelled? ☐ Yes ☐ No *(If "Yes," to the first or first and second questions, please explain.)*

h. How do you learn best? ☐ Seeing ☐ Hearing ☐ Experiencing *(i.e., hands on)*

PART 12 - LEGAL ASSESSMENT

a. Have you ever been arrested? ☐ Yes ☐ No *(If "Yes," please give year and reason.)*

b. Are you currently on probation or parole? ☐ Yes ☐ No *(If "Yes," please give the name of your probation or parole officer.)*

c. Do you presently have any other legal problems? ☐ Yes ☐ No *(If "Yes," please explain.)*

d. (Military only) Have you ever had any administrative actions taken against you? ☐ Yes ☐ No *(If "Yes," please select all that apply.)*
☐ Counseling statement ☐ Letter of reprimand ☐ Article 15 ☐ Court-martial ☐ Chapter

PART 13 - SEXUAL ASSESSMENT

a. Are you experiencing any sexual concerns? ☐ Yes ☐ No *(If "Yes," please explain.)*

b. My sex life is ☐ Good ☐ Fair ☐ Poor ☐ Abstinent

c. Have you ever been sexually abused? ☐ Yes ☐ No *(If "Yes," at what age and by whom?)*

d. Have you ever been sexually abusive to others? ☐ Yes ☐ No *(If "Yes," please explain.)*

e. Do you feel guilty about any past sexual experiences? ☐ Yes ☐ No *(If "Yes," please explain.)*

f. Have you ever had an unwanted pregnancy? ☐ Yes ☐ No ☐ Not applicable *(If "Yes," please explain.)*

g. Has any past or currrent sexual behavior gotten you into trouble? ☐ Yes ☐ No ☐ Not applicable *(If "Yes," please explain.)*

PART 14 - LEISURE, RECREATIONAL AND VOCATIONAL ASSESSMENT

a. What is your present job?

b. Are there any problems with your present job?

c. Job history: *(Select all that apply to you.)* ☐ I have had no career problems
☐ Not working in the field I was trained in ☐ Wondering if I should change jobs ☐ Not liking the people I work with ☐ Combining marriage and a career
☐ Needing career assistance ☐ Not getting promoted ☐ Not liking my supervisor ☐ Experiencing prejudice at work ☐ Lacking experience for a different job
☐ Other career or job problems:

d. If military, what are your plans: ☐ Stay in and reenlist ☐ Stay in until my ETS ☐ Get out ASAP with a good discharge ☐ Get out ASAP with any discharge
☐ I don't know right now

e. If military or a federal civilian employee,

(1) What was your usual job or occupation prior to joining government service? _____

(2) What was the longest period of time you held a job prior to entering government service? _____

f. Which of the following do you do? *(Select all that apply to you.)*
☐ Spend time with friends ☐ Sports/exercise ☐ Classes ☐ Dancing ☐ Time with family ☐ Hobbies ☐ Work part-time ☐ Watch movies/ TV
☐ Go "downtown" ☐ Stay at home ☐ Listen to music ☐ Spend time at clubs/bars ☐ Dancing ☐ Other:

g. What limits your leisure/recreational activities?

PART 15 - NUTRITIONAL ASSESSMENT

a. Do you usually eat three meals per day? ☐ Yes ☐ No *(If "No," please explain.)*

b. Do you drink caffeinated beverages? ☐ Yes ☐ No *(If "Yes," how many and what type (i.e., coffee, tea, soda, etc.))*

c. Do you have 3 or more drinks of beer, liquor or wine almost every day? ☐ Yes ☐ No

d. Are you satisfied with your present weight? ☐ Yes ☐ No *(If "No," please explain.)*

e. Do you eat few fruits or vegetables, or milk products? ☐ Yes ☐ No

f. In the last 6 months, have you gained or lost 10 or more pounds without trying? ☐ Yes ☐ No *(If "No," please explain.)*

g. Have you ever had problems with your weight in the past? ☐ Yes ☐ No *(If "No," please explain.)*

h. Have you ever had problems with binge eating or compulsive overeating? ☐ Yes ☐ No *(If "No," please explain.)*

i. Have you ever had problems with purging (i.e., making yourself vomit)? ☐ Yes ☐ No *(If "No," please explain.)*

PART 15 - NUTRITIONAL ASSESSMENT *(Continued)*

j. Are you experiencing frequent nausea and vomiting of more than 3 days in duration? ☐ Yes ☐ No *(If "Yes," please explain.)*

k. Do you experience difficulty chewing or swallowing that causes you to eat less than normal amounts of food? ☐ Yes ☐ No *(If "Yes," please explain.)*

l. Are you experiencing any other nutritional problems not asked in this section? ☐ Yes ☐ No *(If "Yes," please explain.)*

PART 16 - FINANCIAL ASSESSMENT *(Continued)*

a. Who handles finances in your home?

b. Do you currently have any financial problems? ☐ Yes ☐ No *(If "Yes," please explain.)*

c. Do you need financial counseling? ☐ Yes ☐ No

d. Have you ever had any of the following problems? *(Select all that apply to you.)*
☐ Garnished wages ☐ Having "no pay due" ☐ Filed bankruptcy ☐ No money for food ☐ Bounced checks ☐ Had to pawn items to make ends meet
☐ Received financial counseling ☐ Been disciplined for bad depts ☐ Had items repossessed ☐ Been late on payments/loans

PART 17 - PATIENT DISCLOSURE

Please use this space to tell us anyting additional that you may feel is relevant or that may be important for your provider to know.

Patient's signature: _____ Date signed: _____

END OF PATIENT SECTION OF QUESTIONNAIRE